ARIZONA DEPARTMENT OF HEALTH SERVICES
High Risk Perinatal Program / Newborn Intensive Care Program
Financial Questionnaire

Place Required Label Here

FINANCIAL QUESTIONNAIRE

1. Infant's Last Name	2. Suffix	3. First Name	4. MI	5. DOB
6. Last Name (Responsible Person)	7. Suffix	8. First Name	9. MI	10. DOB

11. Insured Last Name	12. Suffix	13. First Name	14. MI

15. Infant's Insurance Coverage Type ☐ 3rd Party Private ☐ AHCCCS ☐ KidsCare ☐ IHS non-AHCCCS ☐ None	16. Infant's AHCCCS Status ☐ Eligible ☐ Ineligible ☐ Pending ☐ Refused
17. Infant's AHCCCS #	18. Infant's AHCCCS Eligibility Date

FAMILY FINANCIAL INFORMATION

The enrolling hospital will provide the family with a Financial Worksheet prior to completing this form. The Financial Questionnaire must be completed for all families seeking 'Full Participation' for financial assistance.

Medical expenses are defined as medical, vision and dental expenses, including insurance premiums, incurred during the 12 months prior to the infant's date of birth. Do **not** include expenses paid or expected to be paid by any third party insurance payor. Do **not** include current charges for infant's stay in the intensive care unit. **DO** include mother's prenatal care, mother's hospital charges and baby's hospital charges before transported (if not enrolled in HRPP/NICP at that hospital)

DETERMINATION OF FAMILY LIABILITY – Complete Financial Worksheet first.

A. Household Size ☐ Include newborn(s), parent(s), siblings & any Dependant(s) claimed on latest tax forms.

B. Total **Gross** Household Income $ _____ Include current income of both parents, if working. Do not include income of other family members such as grandparents, unless they are assuming financial responsibility for the baby.

C. Less Medical Expenses from **Financial Worksheet** $ _____

D. Adjusted Gross Income (B minus C) $ _____

E. NICP Family Liability taken from the ADHS Family Liability Table (Use A and D above) $ _____

☐ I hereby request financial assistance for payment of expenses for transport and/or care in the hospital intensive or intermediate care center in accordance with the policies of the Arizona Department of Health Services (ADHS). I agree to enroll my infant in any insurance he/she is eligible for: private, AHCCCS, or IHS within thirty (30) days from infant's date of birth, and understand that failure to do so will result in denial of NICP financial assistance. I agree to submit all necessary documents on behalf of my child/children for purpose of collection from all third party payors and shall retain no insurance proceeds from claims intended as payment for services provided. I shall assist all providers to obtain 3rd party payments. I have completed the HRPP/NICP Financial Worksheet prior to this HRPP/NICP Financial Questionnaire, and will receive copies of both from the hospital representative after signing below. I understand that financial assistance is not available for services rendered by out-of-state hospitals or physicians or care through non-contracted hospitals. I authorize the release of any necessary medical, social or financial information held by any institution or individual that provided newborn services to my child/children to the Arizona Department of Health Services or their contracted providers for provider quality management purposes. **I understand that if my Household Income changes during the first 60 days from my infant's date of birth, I may contact the hospital interviewer to complete a revised financial questionnaire. Any revisions must be received by ADHS within 90 days from infant's date of birth.**

_____ _____ _____
Signature of Parent / Guardian / Responsible Person | Relationship to Patient | Date

_____ _____ _____
Signature of Hospital Interviewer | Printed Name of Interviewer | Date

Interviewer Comments _____

Distribution: Original to ADHS with Financial Worksheet *Yellow to Hospital Billing Office* *Pink to Family*